CHILDREN'S MENTAL HEALTH SERVICES

DOCUMENTATION AND UNIFORM CLINICAL RECORD MANUAL

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

MARCH 2005

UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

A "Uniform Clinical Record and Documentation System" means that the forms used within each level of service are the same.

The forms are not intended to be a substitute for clinical skills or interview structure, and do not include all variables which should be assessed. All prompts mentioned on the forms should be assessed and documented, but the clinician is not limited by what is printed on the forms. The clinician's judgment is the final determinant of additional documentation needs.

PURPOSE OF UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

- Serve as a vehicle for documentation of the client's condition, planned services and response to services provided.
- Document coordination of services between all behavioral health staff providing care to the client (this includes mental health, physical health, and dual diagnosis providers).
- Provide data for use in planning potential services, evaluating outcomes, continuing education and research.

The importance of maintaining a comprehensive, detailed and uniform clinical record and documentation system cannot be overemphasized. The clinical record stores the knowledge concerning the client and his/her care. The content of the clinical record is developed as a result of the interaction of the mental health care team who uses it as a communication tool. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, justify the treatment, record observations, plans, interventions, and the client's responses accurately. The record is the mechanism for continuity among members of the client care team, both within and across encounters.

The client care team is an interdisciplinary group composed of physicians, nurses, psychologists, clinicians, rehabilitation specialists/staff, family and youth support partners, and other healthcare professionals. They communicate their findings, observations, opinions, and treatment of the client through their entries in the record. It is crucial that there be prompt recording of observations, treatment, and care by all who contribute to the care of the client.

Uniformity of the clinical record facilitates access to necessary client information and simplifies review of records. The clinical record is potentially one of the most important and persuasive items of evidence available in counteracting a client's allegation of medical negligence. It is also used for planning future services, evaluating outcomes, collecting data for research, and training. Finally, is also fundamental to payment of claims and subsequent verification of claims.

GENERAL GUIDELINES OF RECORD KEEPING

1. A single medical record per client is to be established. That is, all records from the same provider relating to one client shall be filed together. A complete picture of the client is then available to everyone contributing to the client's continuum of care.

2. Writing is legible so all entries in the clinical record are clear and readable.

3. All portions of the medical record must be legible. Use caution when using double sided forms and hole punching pages.

4. Errors are to be corrected by a single line through the incorrect information with the word "error," written out. Date and initial each corrected entry. Never erase, over-write, ink out, or utilize white out to correct an error.

5. Addendums to an entry already made must be made separately with a printed name, credentials, signature, and date. Such entries are to be labeled "addendum."

6. Use black ink pen or black type only. Never use water base (felt) pens, pencils, or colored print when documenting in the clinical record.

7. Draw a diagonal line through all blank portions of a document.

8. Abbreviations from the approved abbreviations list may only be used.

9. Use behavioral descriptions to document a client's progress.
   Imprecise: Appears depressed.
   Precise: Crying, poor eye contact, states she is not sleeping because she is worried about her illness.

10. Laboratory work reports and radiology examination reports must bear the date the physician reviewed the report and his/her initials.

11. Medication only cases are to follow the guidelines set forth in the Medication-Only Services Policy and Procedure No. 06-01-124.

12. Ensuring no duplication of service is the responsibility of all service providers. All providers are to regularly obtain a client Face Sheet (MHS-140) to assess if other providers are involved, in addition to discussing related services directly with the client. All providers share the responsibility to coordinate services and document service needs.

13. Each page must bear the client's name, client's InSyst number, and program name. This will be found on the T Bar.

14. Medical Record forms which are identified with a T Bar and form number, may not be removed from the medical record.

15. Entries by all staff must be within their scope of practice. Paraprofessionals and unlicensed personnel may only provide services consistent with county and contract guidelines.

16. A "Late Entry" is any documentation that is done on a calendar day other than the date the service was provided. When documenting a "Late Entry" note, enter the Date of Service that the service was provided, not the date the note is being written. When documenting the information of the service provided, the phrase "Late entry for (date service was provided)" should appear in the body of the note, preferably at the beginning of the note. After completion, the note should be signed and dated on the date that it is being written, not the date the service was provided, and should be filed in the medical record chronologically to when it was written, not filed by the date the service was provided. You may wish to insert a note referring to the late entry at the point it would have been included if written at the correct time.

17. Volunteers must have their work supervised by Licensed Mental Health Professionals, and adhere to confidentiality laws. They may only make entries in the medical record when they have authorization from program administration. Any such entries must be co-signed by a supervising Licensed Mental Health Professional.

18. The medical record may be organized with the most recent entry on top (descending order) or in ascending order. However, when the medical record is closed, the record should read like a book, with the newest information at the end.

19. The Uniform Chart Order is to be followed as outlined by the Documentation Manual. Additional program specific information may be inserted as deemed appropriate by the Program, while maintaining the integrity of the Uniform Chart Order.

20. Episode: Only forms and documentation that are generated or obtained during the current episode may be filed in the current treatment sections of the medical record. All other information received in a referral packet or by request shall be filed under previous treatment, except those forms that may be copied and "imported" into the current episode (these are indicated by an asterisk in the chart order). An "episode" is a record of the treatment and services provided to a client between the dates of admission and the discharge.

21. Importing forms from other episodes or providers is appropriate under certain circumstances. See Uniform Chart Order for items that can be imported (noted with an asterisk). When importing a form it is necessary for the current provider to review the content. When accepting the form the new provider shall print his or her name with credential, sign and date the form. The new provider may make additions to the original form by dating and initialing additions. A copy of the imported form is used in lieu of the original and placed in the appropriate section of the medical record.

22. Medical record retention is outlined in the Policy and Procedure number 01-05-11 to be a period of 10 years after the discharge date of adult clients, or until a minor has reached the age of 19, but in no case less than 10 years.

UNIFORM CHART ORDER

Section 1 — **CLIENT DATA**

Client Information Face Sheet	MHS-140-(InSyst Report)
Discharge Summary	HHSA:MHS-653

Section 2 — **ASSESSMENTS**

*Behavioral Health Assessment	HHSA:MHS-650
*Behavioral Health Update	HHSA:MHS-663
Mental Health Assessment Pursuant to AB2726	
Initial Screening Form	HHSA:MHS-607
*Youth Transition Self Evaluation	HHSA:MHS-624
Transitional Youth Referral Plan	HHSA:MHS-605
Psychological Testing and Evaluations	

Section 3 — **OUTCOME EVALUATIONS**

Section 4 — **PLANS**

Client Plan	HHSA:MHS-646
IEP Mental Health Treatment Plan (AB2726)	
Therapeutic Behavioral Services Treatment Plan	HHSA:MHS-919
Authorization (day programs and ancillary services)	UBH 12-13-02
Utilization Review Request and Authorization (OP & CMBR)	HHSA:MHS-662

Section 5 — **PROGRESS NOTES (chronological order)**

Individual Progress Note	HHSA:MHS-925
Group Progress Note	HHSA:MHS-924
Progress Note – Other Services (2 versions: form fill / hard copy)	HHSA:MHS-926
TBS Progress Note	HHSA:MHS-603
Day Program – Weekly Summary (with or without prompts)	HHSA:MHS-613 A or B
Day Program – Progress Note	HHSA:MHS-604

Billing Record may be filed in this section or kept in a separate confidential location – minimum 7 years
Day Programs include monthly and quarterly reports in chronological order – when applicable

Section 6 — **MEDICAL**

Medication Profile	HHSA:MHS-913
Informed Consent for the Use of Psychotropic Medications (or Ex Parte)	HHSA:MHS-005
Psychiatric/Medication Evaluation	HHSA:MHS-645
Medication Follow-Up	HHSA:MHS-689
Laboratory Reports	
Physician's Order Form	HHSA:MHS-985
*Child/Youth History Questionnaire	HHSA:MHS-651
Advance Directive Advisement (Adult clients and emancipated minors)	HHSA:MHS-611
Advance Directive (when provided)	

Section 7 — **ADMINISTRATIVE/LEGAL (for county programs)**

Consent for Mental Health Services	HHSA:MHS-272
Dependents: Consent for Treatment – Parent	04-24P (06/03)
Ex-parte or Court Order	04-24C (04/04)
Authorization to Use or Disclose Protected Health Information	HHSA:23-07(04/03) 14 font
Dependents: Authorization to Use or Disclose Protected Health Info.	04-24A-P (03/04)
Ex-parte or Court Order	04-24A-C (04/04)
Authorization for Use or Disclosure of Health Information to School Districts	
Request for Access and/or Copy of Protected Health Information	HHSA 23-01 (04/03)
Client Financial Information	HHSA:MHS-487
Acknowledgment of Receipt (County NPP)	NPP – 001(03/21/2003) Page 8 of 8
Treatment Record Requests	

Section 8 — **INTERAGENCY REPORTS**

Section 9 — **SCHOOL REPORTS**

Section 10 — **CORRESPONDENCES**

Correspondence Received
Correspondence Sent Out

Section 11 — **PREVIOUS TREATMENTS**

Past SDMHS System Treatment Services
Previous Treatment Records
Residential Placements

*Forms which may be copied and "imported" for use in current episode and updated or redone if there is a change in the client's status.

March, 2005

SECTION I

CLIENT DATA

CLIENT INFORMATION FACE SHEET
(InSyst MHS-140)
Generated by InSyst

WHEN:

Data is entered into InSyst when a client episode is opened and when changes to any of the required elements occur. A current Face Sheet (MHS-140) shall be placed in the client's record and at a minimum updated on a quarterly basis.

ON WHOM:

All clients with an open episode.

COMPLETED BY:

InSyst generates this printout based on information entered by each program that has an open episode of the client. Traditionally entered by program's data entry staff.

MODE OF COMPLETION:

For clients who are not previously registered in the system the following two United Behavioral Health (UBH) forms are to be completed and entered into InSyst:

1. InSyst Client Registration Form
2. Episode Opening / Closing Form.

For clients who are registered in the system the following UBH form is to be completed and entered into InSyst:

1. Episode Opening / Closing Form.

On an annual basis UBH prompts programs to enter data on all open clients. The following UBH CSI form is completed and entered into InSyst:

1. Client and Service Information Annual Update (CSI).

Additionally, changes in the client status shall be entered into InSyst as they occur.

Upon closing of an episode the following UBH form is to be completed and entered into InSyst:

1. Episode Opening / Closing Form.

REQUIRED ELEMENTS:

The Client Registration, Client Management, Client Address, Client Significant Other, and Episode Management screens must have all required data elements completed prior to requesting the MHS140 Face Sheet. If any information is not available at intake, it shall be obtained for entry into InSyst as soon as possible.

BILLING:

Data entry is a clerical function and therefore not billable.

NOTE:

This form is not a standard medical record form, therefore program discretion shall be exercised in determining whether to maintain previous face sheets. Most current Face Sheet is to be maintained in the record.

March, 2005

CLIENT INFORMATION FACE SHEET

Report MHS 140
Run Date: 21-MAY-1993
Page: 1

CONSUMER INFORMATION

Name: WILLIAM DITHERS
Address: 935 SUMMER WAY
GOLDVILLE, CA 99697
Phone: ( ) -
Staff:
Unknown
Aliases: None
RP Owes: $57.00
Insurance: MOLINA MEDICAL CENTER (1121)

Number: 10588
SSN: 588-49-1234
Other ID #: 110789
Marital: Never Married
Disability: None

Birthdate: 15-AUG-1977
Sex: F Age: 15
Language: English
Education: 8 years
Ethnicity: White Hispanic Origin:

Medicaid: 588491234 Last Eligibility: 2/1993

SIGNIFICANT OTHERS

Name: _____ Relationship: _____

Address: _____ Phone: Day: ____-_____ Night: ____-_____

CLINICAL HISTORY

Legal Provider	Opening	Closing	Primary Diagnosis	Clinician	Physician	Total Units	Last Service	Legal Status Consent
-----OPEN EPISODES----------								
CMP	16-NOV-1992		298.90	KRILL, DARRYL	JOHNSON	13	22-FEB-1993	W60000
WSCP	7-FEB-1992		295.70	KRILL, DARRYL	JOHNSON	22	2-FEB-1993	W60000
-----CLOSED EPISODES----------								
PHF	23-FEB-1993	23-FEB-1993	295.90	TRAN, TIEN	TRAN, TIEN	0		W51500
PHF	2-FEB-1993	3-FEB-1993	295.90	TRAN, TIEN	TRAN, TIEN	0		W51500
PHF	26-JUL-1992	26-JUL-1992	295.90	TRAN, TIEN	TRAN, TIEN	1	26-JUL-1992	W51500
MTZ CRISIS	21-AUG-1991	21-AUG-1991	295.70	WILSON	DAVIS	1	21-AUG-1991	W60000
MTZ CRISIS	6-AUG-1991	16-AUG-1991	295.70	ROBERTS	DAVIS	2	16-AUG-1991	W60000

Total Episode Count = 7

****
Confidential Information
****

DISCHARGE SUMMARY

WHEN:

Within 14 calendar days of discharge for clients seen five or more times. When seen five or less times, complete a discharge progress note.

ON WHOM:

Upon planned or unplanned closing of an episode.

All clients not seen for three months, unless the clinician has documented the reason for absence and it is reasonably expected that the client will receive services within six months.

When a case is transferred to a medication only case, the clinician shall complete the Discharge Summary and a progress note indicating client transfer to medication only services.

COMPLETED BY:

MD, clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, or RN (with Masters Degree and psychiatric specialty), trainee with a co-signature by a supervising LPHA or LPHA Waivered.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Discharge Summary form (MHS-653).

REQUIRED ELEMENTS:

- Date of admission and of discharge from current provider or date of transfer to medication only status.
- Identifying information capturing client's age, DOB, gender, and ethnicity.
- Cultural accommodations provided during treatment or offered as follow up.
- Principal (treated) five-axis diagnoses, capturing any dual diagnosis issue that was a focus of treatment and notation of dual diagnosis status.
- Reason for admission to the program.
- Strengths for both the client and family.
- Risk assessment history that distinguishes between past and present risks.
- Case summary that indicates if client plan goal(s) were met as well as type and impact of treatment approaches utilized. Outline reason for discharge from the program followed by outline of aftercare plan that includes client's living arrangements, school status, and any recommendations. Include any specific referrals with appointment date and time, as well as substance abuse treatment recommendations when applicable.

- Discharge medication, outlining current medication(s) name, dose, frequency and if taken as prescribed. Outline if client was referred to pediatrician or to another provider for psychotropic medication follow up. Indicate any medical cautions or allergies.
- Clinician's printed name, credentials, and signature, with date of form completion.
- When completed by a trainee, include clinical supervisor's printed name, credentials, and signature, with date of review.
- T Bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

Billing for completing a discharge summary shall only occur when it is connected to a direct client service such as an individual session by a clinician. Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

When completing a Discharge Summary that is not connected to a direct client service, document work on a progress note and utilize a non billable code and corresponding billing record.

For Day Programs which provide an all inclusive rate, document the completion of a Discharge Summary on the daily note or weekly summary.

Date of Admission: _____ **Date of Discharge:** _____
Date of Transfer to Meds Only: _____

I. IDENTIFYING INFORMATION

Client's Age: _____ **DOB:** _____ **Client's Gender:** ☐Male ☐Female

Client's Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander: _____
☐ Caucasian ☐ American Indian ☐ Middle Eastern ☐Other: _____

II. CULTURAL ACCOMMODATIONS PROVIDED

☐Were not indicated
☐Utilized interpreter (on going or occasional) Language: _____
☐Bi Lingual provider (on going or occasional) Language: _____
☐Culturally specific referral recommendation: _____

Additional Comments: _____

III. PRINCIPAL DIAGNOSIS

DSM-IV-TR DIAGNOSIS	DIAGNOSTIC CODE
AXIS I	
AXIS I	
AXIS I	
AXIS II	
AXIS III Relevant Medical Conditions:	
AXIS IV Psychosocial and Environmental Problems:	
AXIS V **Current GAF:** **Highest GAF in Past Year:**	

☐**Yes** ☐**No** Client met additional Dual Diagnosis criteria of having a co-occurring substance use problem that does not meet the criteria for a substance-related diagnosis but causes significant impairment in the youth's life (this information to be captured in the Other Factor codes in InSyst).
☐**Yes** ☐**No** Client met additional Dual Diagnosis criteria of having a parent, caretaker, or significant other with a substance use problem. When familial substance use problem causes impairment in youth's life it may be noted on Axis IV above (this information to be captured in the Other Factor codes in InSyst).

IV. REASON FOR ADMISSION

_____
_____
_____
_____
_____

V. STRENGTHS

Client: _____
Family: _____
_____

RISK ASSESSMENT HISTORY

☐Aggression ☐Fire Setting ☐Criminal Activity ☐Sexual Acting Out
☐Suicide Attempts ☐Runaway ☐Truancy ☐Explosion ☐School Dropout

Other pertinent risk issues when applicable (distinguish between past and present): _____
_____

VI. CASE SUMMARY

Client Plan goal(s) were met: ☐Yes ☐No ☐Partially

Treatment approaches and progress on Client Plan goals:

_____

_____

_____

Reason for discharge:

☐Additional treatment not indicated at this time
☐Transfer to medication only
☐Failure to return to treatment
☐Discharge due to inconsistent attendance
☐Assessment completed. Client referred for treatment.

_____

_____

Outline aftercare plan that includes client's living arrangements, school status, and any recommendations:

_____

_____

Referred to: _____ Appointment Date: _____ Time: _____

Substance abuse treatment recommendations: ☐Not Applicable ☐_____

VII. DISCHARGE MEDICATION

Current Medication(s)	Current Dose	Frequency	Taken as Prescribed?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

☐Psychotropic medication is not indicated at this time
☐Referred to pediatrician for psychotropic medication: _____
☐Referred to the following provider/clinic for psychotropic medication follow up: _____
☐Client or caregiver declines referral for psychotropic medication.
☐Medical cautions / allergies: _____

Additional Information (when applicable): _____

_____

Completed by:

_____ _____
Print name Credentials

_____ _____
Signature Date

Reviewed by:

_____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Print name, credentials, signature

_____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Print name, credentials, signature

SECTION II

ASSESSMENTS

BEHAVIORAL HEALTH ASSESSMENT

WHEN:

Within 30 calendar days of opening the client's episode.

When significant changes occur the assessment may be revised by adding information, noting the date and initialing the addendum, or a new assessment or update may be completed.

ON WHOM:

All clients seeking mental health services who are provided with a face to face assessment.

COMPLETED BY:

MD, clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, or RN (with Masters Degree and psychiatric specialty), trainee with a co-signature by a supervising LPHA or LPHA Waivered.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Behavioral Health Assessment form (MHS-650).

REQUIRED ELEMENTS:

- Date of assessment.
- Identifying information, which includes client's age, DOB, gender, and ethnicity.
- Source of information.
- Presenting problem/needs, which includes the precipitating factors that led to behavior(s), with description of events in sequence leading to present visit.
- Client and family strengths.
- Potential for harm/risk assessment.
- Current functioning utilizing the Quadrant model.
- School history, outlining current functioning.
- History of treatment, which includes mental health, substance abuse treatment, and any psychotropic prescribed medications.
- Social history with current issues.
- Family history with current issues.
- Developmental/Medical History with outline of current medications, remembering to note any known allergies on chart jacket. Additionally, be sure note any physical health issues and medications through the pediatrician or any other specialist.
- Mental status exam.
- Substance use information, which includes the CRAFFT measure and outline of substance use by drug category. CRAFFT measure may be administered verbally to client (without interpretation of questions) or handed out on a separate sheet of paper with responses transferred to assessment.
- Cultural issues.

- Clinical conclusion, which includes plan, recommendations, need for further evaluations, and/or referrals.
- DSM-IV-TR Diagnoses – current 5 axis with dual diagnosis subsections (including diagnostic code number).
- Freedom of Choice.
- Beneficiary protection information.
- Clinician's printed name, credentials, and signature with date of form completion.
- Reviewer's printed name, credentials, and signature with date of review and/or revisions to form.
- T Bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

For Day Programs which provide an all inclusive rate, document the completion of a Behavioral Health Assessment on the daily note or weekly summary.

NOTE:

An existing assessment may be imported from a previous episode, provider or program and utilized in a current episode. However, the current lead clinician must review and accept the assessment by signing the last page AND a Behavioral Health Update must be completed within the first 30 days.

Therapeutic Behavioral Services (TBS) may import and utilize an existing Behavioral Health Assessment that is current (up to one year old) without needing to complete a Behavioral Health Update. Case Manager must sign off on the assessment with current date to indicate review and acceptance of information. When the assessment expires, TBS may import and accept a Behavioral Health Update from the Specialty Mental Health Provider. Annual beneficiary protection material continues to be a requirement and needs to be documented in the Progress Note section during the intake process.

Cases transferred to medication only are exempt from updating the assessment. However, the annual beneficiary protection material continues to be a requirement and needs to be documented in the Progress Note section.

Date of Assessment: _____

I. IDENTIFYING INFORMATION

Client's Age: _____ **DOB:** _____ **Client's Gender:** ☐Male ☐Female

Client's Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander: _____
☐ Caucasian ☐ American Indian ☐ Middle Eastern ☐ Other: _____

II. SOURCE OF INFORMATION

☐Client ☐Parent ☐Foster Parent ☐Social Worker ☐AB2726 Assessor ☐Teacher/School ☐Prior Therapist ☐MD ☐PO ☐ADS Recovery Provider

Reports Reviewed: _____

Referral Source: _____

Other: _____

III. PRESENTING PROBLEM/NEEDS (Include precipitating factors that led to behavior(s), and describe events in sequence leading to present visit)

IV. STRENGTHS (Include strengths related to successful management of mental health symptoms and/or substance use)

Client: _____

Family: _____

V. POTENTIAL FOR HARM / RISK ASSESSMENT

Current SI	☐ No	☐ Yes	Specify plan (vague, passive, imminent): _____
Access to Means	☐ No	☐ Yes	_____
Previous Attempts	☐ No	☐ Yes	_____
Client Plan for Safety	☐ N/A	☐ Yes	See Progress Note dated: _____
Current HI	☐ No	☐ Yes	Specify Plan (vague, intent, with/without means): _____
Identified Victim	☐ No	☐ Yes	Name and contact information: _____
Tarasoff Warning:	☐ No	☐ Yes	_____
Client No Harm Plan:	☐ N/A	☐ Yes	See Progress Note dated: _____

Other Risk Factors when applicable:

_____

_____

_____

VI. CURRENT FUNCTIONING

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Actively	☐Suicidal ☐ Fire Setting ☐Homicidal ☐Psychotic			☐None
School	☐Expelled ☐Increased Placement Level ☐Chronic Truancy ☐Threats to Staff or Students ☐Major Property Damage	☐Failure ☐ Significant Decline ☐ Frequent Truancy/Non-Excused Absences ☐ Frequently Disruptive	☐Declining Grades ☐ Poor Attention ☐ Periodic Behavior Problems ☐ Producing Less Than Expected Level	☐Regular Attendance ☐Minimal Behavior Problems
Home	☐ Threats to Family Members ☐ AWOL/Running Away ☐ Severe Property Damage ☐ Serious and Repeated Violations of Rules/Laws	☐Overnight Running Away ☐Moderate Property Damage ☐Persistent Failure to Comply with Reasonable Rules	☐Episodic Property Damage ☐Frequent Disobedience and/or Resistance	☐Occasional Disobedience
Thinking	☐Active Thought Disorder ☐Dissociation ☐Disorientation	☐Disorganized Communication ☐Distortion of Thinking ☐Occasional Reality Impairment (Suspicions/Obsessions)	☐Odd Beliefs ☐Unusual Perceptions ☐Eccentric	☐No disturbance in Thinking ☐Normal Concerns
Substance	☐Dependence, ☐Frequently Intoxicated or High (More than twice per week)	☐Abuse with Interference of Functioning	☐Recurrent Use with Minimal Interference of Functioning	☐Occasional ☐No Use ☐Full Remission
Mood	☐Persistent and Incapacitating	☐Intense and Abrupt Episodes ☐Marked Mood Changes ☐Blunt Affect ☐ Significantly Withdrawn / Isolative	☐Anxious ☐ Self Critical ☐ Fearful/Sad with Overt sx ☐ Low Self Esteem ☐ Easily Distressed ☐ Restricted Affect	☐Normal Reactions to Life Events ☐Expresses Emotions Appropriately
Self Harm	☐Active Clear Plan ☐Serious Self Harm	☐Superficial Cuts ☐Suicidal Ideation without Immediate Danger	☐Fleeting Suicidal Ideation ☐Pinching/Scratching Self	☐None
Behavior Toward Others	☐Serious Intent to Cause Harm ☐Seriously Assaultive ☐Serious Repeated Criminal Activity	☐Threats to others ☐Some Aggressive Behaviors ☐Inappropriate Sexual Behavior ☐ Police Involvement	☐Argumentative ☐ Occasional Tantrums ☐ Ignored/Rejected by Peers ☐ Poor Social Skills ☐ Assault History	☐Age Appropriate Behavior
Other				

VII. SCHOOL HISTORY

Area(s) of concern: ☐Academic ☐Behavioral ☐Social ☐No school issue ☐Other: _____

Child is or has been in: ☐Special Education Class ☐Failed the following grade(s): _____

Client has an active IEP: ☐No ☐Yes

Current School: _____ Grade: _____

VIII. HISTORY OF TREATMENT (Previous symptoms, treatment dates, providers, medications, interventions, and responses)

☐ No previous mental health treatment reported
☐ No previous substance abuse treatment reported
☐ No previous psychotropic medications reported

IX. SOCIAL HISTORY

Peer / Social Support: ☐Yes ☐No _____

Substance Use by Peers: ☐Yes ☐No _____

Gang Affiliation: ☐Yes ☐No _____

Sexuality Concerns: ☐Yes ☐No _____

Additional Information (when applicable): _____

X. FAMILY HISTORY

Client's Living Situation: ☐home ☐foster home ☐group home ☐residential facility ☐other: _____

Those living in the home with client: _____

Have any relatives ever had any of the following conditions (indicate who and expand below when applicable):

☐Substance abuse or addiction _____ ☐Suicidal thoughts, attempts _____

☐Other addictions _____ ☐Mental retardation _____

☐Developmental Delays _____ ☐Emotional problems _____

☐Arrests _____ ☐Other: _____

When applicable include immigration, acculturation and other relevant information such as parents' marital status, sibling relationships, and system involvement such as child welfare, probation, incarceration:

XI. DEVELOPMENTAL/MEDICAL HISTORY

Allergies: ☐NKA ☐Yes: _____

Head Injuries: ☐No ☐Yes: _____

Hospitalization (mental or physical health): ☐No ☐Yes: _____

Pediatrician's Name: _____

Physical Health Issues: ☐None at this time ☐Yes: _____

Physical health evaluation by pediatrician recommended: ☐No (recent physical reported) ☐Yes: _____

Psychiatric Evaluation: ☐No referrals made at this time ☐Currently treated by: _____

☐Referral to: _____

Significant Developmental Information (when applicable): _____

Current Medication(s) Date	Name of Medication	**Current Dose**	**Frequency**	**Taken as Prescribed?**
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

XII. MENTAL STATUS EXAM

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous	☐		
Orientation:	☐Person	☐Place	☐Time	☐Current Situation		☐
Appearance:	Hygiene ☐Good ☐Poor	☐Reddened Eyes	Age Appropriate Dress ☐Yes ☐No	Appears to be: ☐Normal Weight ☐Overweight ☐Underweight		
Speech:	☐Normal	☐Slurred	☐Loud ☐Soft	☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial	☐Incoherent	☐Loose Association	☐
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative	☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐ Restricted	☐Blunted	☐Flat	☐Labile	☐
Intellect:	☐Average	☐Below Average	☐Above Average	☐Age Appropriate Vocabulary		☐
Mood:	☐Euthymic	☐Elevated	☐Irritable	☐Depressed	☐Anxious	☐
Memory:	☐ Normal	☐ Poor Recent	☐ Poor Remote	☐Inability to Concentrate	☐	
Motor:	☐ Age Appropriate	☐Slowed	☐ Hyperactive	☐ Tremors	☐Tics	☐Repetitive Motions
Judgment:	☐ Age Appropriate	☐Poor	☐Fair	☐Limited	☐	
Insight:	☐ Age Appropriate	☐Poor	☐Fair	☐Limited	☐	

Other observations when applicable:

_____

_____

Visual Hallucinations: ☐No ☐Yes _____

Auditory Hallucinations: ☐No ☐Yes _____

Delusions: ☐No ☐Yes _____

XIII. SUBSTANCE USE INFORMATION

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

HAVE YOU EVER?		Yes	No
1.	Have you ever ridden in a **Car** driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐	☐
2.	Do you ever use alcohol or drugs to **Relax**, feel better about yourself, or fit in?	☐	☐
3.	Do you ever use alcohol or drugs while you are by yourself **Alone**?	☐	☐
4.	Do you ever **Forget** things you did while using alcohol or drugs?	☐	☐
5.	Do your **Family or Friends** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6.	Have you ever gotten into **Trouble** while you were using alcohol or drugs?	☐	☐

2 or more yes answers suggest dual diagnosis issues and should be explored further. **TOTALS:** _____ _____

Name of Drug	Never Used	Age First Used	Days of Use in last 30 days	Amount Used on typical day	Largest Amount Used in One Day	Method of Administration
Caffeine						
Cigarettes						
Alcohol						
Marijuana/Hashish						
Methamphetamine (stimulant): speed, crystal						
Cocaine (stimulant): crack, snow, coca, roca, rock						
Inhalants: glue, gasoline, nitro, paint						
Prescription Drugs: Valium, Librium, Tranquilizers, etc						
Hallucinogen: LSD, acid, tabs, ecstasy, Mushroom, MDA						
PCP, DIP, (supercool or sherm stick)						
Heroin (depressant): chiva, carga, junk, slam, stuff						
Speedballs (Cocaine mixed with Heroin), Belushi, speedy						
Narcotics						
Barbiturates						
Other Drugs (including over the counter)						

When applicable, outline how above use impacts current level of functioning:

_____

_____

_____

Recommendation for further substance use treatment ☐not applicable ☐no ☐yes Specify:

_____

_____

_____

XIV. CULTURE

Birthplace: _____ Year moved to USA (when applicable): _____

Client's language of choice for services: ☐English ☐Spanish ☐Vietnamese ☐Arabic ☐Other: _____

Parent/Guardian's language of choice for services: ☐English ☐Spanish ☐Vietnamese ☐Arabic ☐Other: _____

Religious Preference: _____

Culture specific symptomotology/explanations for behavior when applicable: _____

XV. CLINICAL CONCLUSION (Include plan, recommendations, need for further evaluation, and/or referrals)

DSM-IV-TR DIAGNOSIS (CURRENT)	DIAGNOSTIC CODE
AXIS I	
AXIS I	
AXIS I	
AXIS II	
AXIS III Relevant Medical Conditions:	
AXIS IV Psychosocial and Environmental Problems:	
AXIS V Current GAF: Highest GAF in Past Year:	

☐Yes ☐No Client meets additional Dual Diagnosis criteria of having a co-occurring substance use problem that does not meet the criteria for a substance-related diagnosis but causes significant impairment in the youth's life (this information to be captured in the Other Factor codes in InSyst).

☐Yes ☐No Client meets additional Dual Diagnosis criteria of having a parent, caretaker, or significant other with a substance use problem. When familial substance use problem causes impairment in youth's life it may be noted on Axis IV above (this information to be captured in the Other Factor codes in InSyst).

Medical Necessity Met: ☐Yes ☐No When **"no"** note date **NOA-A Issued** (Medi-Cal Clients only): _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Beneficiary Handbook was offered on:** _____

☐ **Grievance and Appeal Process explained and Brochure offered on:** _____

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:** _____

☐ **Language/Interpretation services availability reviewed and offered when applicable on:** _____

Completed by: _____ _____
Print name Credentials

_____ _____
Signature Date

Reviewed by: _____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Printed name, credentials, signature

_____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Printed name, credentials, signature

BEHAVIORAL HEALTH UPDATE

WHEN:

Within 30 calendar days of opening the client's episode when a Behavioral Health Assessment has been accepted and imported to current episode.

Up to 30 calendar days prior to the anniversary of the current episode opening date. Updates are done annually.

When significant changes occur the update may be revised by adding information, noting the date and initialing the addendum, or a new update may be completed.

ON WHOM:

All clients receiving mental health services.

COMPLETED BY:

MD, clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, or RN (with Masters Degree and psychiatric specialty), trainee with a co-signature by a supervising LPHA or LPHA Waivered.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Behavioral Health Update form (MHS-663).

REQUIRED ELEMENTS:

- Date of update.
- Identifying information, which includes client's age, DOB, gender, and ethnicity.
- Source of information.
- Current problem/needs outlining status on Client Plan goals.
- Client and family strengths.
- Current risk assessment.
- School update.
- Current functioning utilizing the Quadrant model.
- Medical update with current medication(s).
- Current substance use information, which includes the CRAFFT measure and outline of substance use by drug category. CRAFFT measure may be administered verbally to client (without interpretation of questions) or handed out on a separate sheet of paper with responses transferred to update.
- Family update.
- Ongoing cultural accommodations.

- Clinical conclusion, which includes plan, recommendations, need for further evaluations, and/or referrals.
- DSM-IV-TR Diagnosis – current 5 axes with dual diagnosis subsections.
- Freedom of Choice.
- Beneficiary protection information.
- Clinician's printed name, credentials, and signature with date of form completion.
- Reviewer's printed name, credentials, and signature with date of review and/or revisions to form.
- T Bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

For Day Programs which provide an all inclusive rate, document the completion of a Behavioral Health Update on the daily note or weekly summary.

NOTE:

When a revision is made to the DSM-IV-TR Diagnosis, and/or dual diagnosis subcategories, it must be entered into InSyst.

Date of Update: _____

I. IDENTIFYING INFORMATION

Client's Age: _____ **DOB:** _____ **Client's Gender:** ☐Male ☐Female

Client's Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander: _____

☐ Caucasian ☐ American Indian ☐ Middle Eastern ☐ Other: _____

II. SOURCE OF INFORMATION

☐Client ☐Parent ☐Foster Parent ☐Social Worker ☐AB2726 Assessor ☐Teacher/School ☐Prior Therapist ☐MD ☐PO ☐ADS Recovery Provider

Referral Source: _____

Other: _____

III. CURRENT PROBLEM/NEEDS (Status on Client Plan goals since last behavioral health assessment or update)

_____

_____

_____

_____

_____

_____

IV. STRENGTHS (Include strengths related to successful management of mental health symptoms and/or substance use)

Client: _____

_____

Family: _____

_____

_____

V. CURRENT RISK ASSESSMENT

☐No current risk identified

_____

_____

VI. SCHOOL UPDATE

Area(s) of concern: ☐Academic ☐Behavioral ☐Social ☐No school issue ☐Other: _____

Child is or has been in: ☐Special Education Class ☐Failed the following grade(s): _____

Client has an active IEP: ☐No ☐Yes

Current School: _____ Grade: _____

_____

_____

_____

_____

_____

_____

VII. CURRENT FUNCTIONING

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Actively	☐Suicidal ☐Fire Setting ☐Homicidal ☐Psychotic			☐None
School	☐Expelled ☐Increased Placement Level ☐Chronic Truancy ☐Threats to Staff or Students ☐Major Property Damage	☐Failure ☐Significant Decline ☐Frequent Truancy / Non-Excused Absences ☐Frequently Disruptive	☐Declining Grades ☐Poor Attention ☐Periodic Behavior Problems ☐Producing Less Than Expected Level	☐Regular Attendance ☐Minimal Behavior Problems
Home	☐Threats to Family Members ☐AWOL/Running Away ☐Severe Property Damage ☐Serious and Repeated Violations of Rules/Laws	☐Overnight Running Away ☐Moderate Property Damage ☐Persistent Failure to Comply with Reasonable Rules.	☐Episodic Property Damage ☐Frequent Disobedience and/or Resistance	☐Occasional Disobedience
Thinking	☐Active Thought Disorder ☐Dissociation ☐Disorientation	☐Disorganized Communication ☐Distortion of Thinking ☐Occasional Reality Impairment (Suspicions/Obsessions)	☐Odd Beliefs, ☐Unusual Perceptions ☐Eccentric	☐No disturbance in Thinking ☐Normal Concerns
Substance	☐Dependence ☐Frequently Intoxicated or High (More than twice per week)	☐Abuse with Interference of Functioning	☐Recurrent Use with Minimal Interference of Functioning	☐Occasional ☐No Use ☐Full Remission
Mood	☐Persistent and Incapacitating	☐Intense and Abrupt Episodes ☐Marked Mood Changes ☐Blunt Affect ☐Significantly Withdrawn / Isolative	☐Anxious ☐Self Critical ☐Fearful/Sad with Overt sx ☐Low Self Esteem ☐Easily Distressed ☐Restricted Affect	☐Normal Reactions to Life Events ☐Expresses Emotions Appropriately
Self Harm	☐Active Clear Plan ☐Serious Self Harm	☐Superficial Cuts ☐Suicidal Ideation without Immediate Danger	☐Fleeting Suicidal Ideation ☐Pinching/Scratching Self	☐None
Behavior Toward Others	☐Serious Intent to Cause Harm ☐Seriously Assaultive ☐Serious Repeated Criminal Activity	☐Threats to others ☐Some Aggressive Behaviors ☐Inappropriate Sexual Behavior ☐Police Involvement	☐Argumentative ☐Occasional Tantrums ☐Ignored/Rejected by Peers ☐Poor Social Skills ☐Assault History	☐Age Appropriate Behavior
Other				

VIII. MEDICAL UPDATE

Pediatrician's Name: _____

Hospitalization (mental or physical health) since last assessment: ☐No ☐Yes: _____

Physical Health Issues: ☐None at this time ☐Yes: _____

Physical health evaluation by pediatrician recommended: ☐No (recent physical reported) ☐Yes: _____

Current Psychiatric Treatment: ☐No referrals made at this time ☐Currently treated by: _____

Current Medication(s) Date	Name of Medication	**Current Dose**	**Frequency**	**Taken as Prescribed?**
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Additional Information (when applicable): _____

IX. CURRENT SUBSTANCE USE INFORMATION

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

HAVE YOU EVER?		Yes	No
1.	Have you ever ridden in a **Car** driven by someone (including yourself) who was high or had been using alcohol or drugs?	☐	☐
2.	Do you ever use alcohol or drugs to **Relax**, feel better about yourself, or fit in?	☐	☐
3.	Do you ever use alcohol or drugs while you are by yourself **Alone**?	☐	☐
4.	Do you ever **Forget** things you did while using alcohol or drugs?	☐	☐
5.	Do your **Family or Friends** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6.	Have you ever gotten into **Trouble** while you were using alcohol or drugs?	☐	☐

2 or more yes answers suggest dual diagnosis issues and should be explored further. **TOTALS:** _____ _____

Name of Drug	Never Used	Age First Used	Days of Use in last 30 days	Amount Used on typical day	Largest Amount Used in One Day	Method of Administration
Caffeine						
Cigarettes						
Alcohol						
Marijuana/Hashish						
Methamphetamine (stimulant): speed, crystal						
Cocaine (stimulant): crack, snow, coca, roca, rock						
Inhalants: glue, gasoline, nitro, paint						
Prescription Drugs: Valium, Librium, Tranquilizers, etc						
Hallucinogen: LSD, acid, tabs, ecstasy, Mushroom, MDA						
PCP, DIP, (supercool or sherm stick)						
Heroin (depressant): chiva, carga, junk, slam, stuff						
Speedballs (Cocaine mixed with Heroin), Belushi, speedy						
Narcotics						
Barbiturates						
Other Drugs (including over the counter)						

When applicable, outline how above use impacts current level of functioning:

_____

_____

_____

Recommendation for further substance use treatment ☐not applicable ☐no ☐yes Specify:

_____

_____

_____

X. FAMILY UPDATE

Client's Living Situation: ☐home ☐foster home ☐group home ☐residential facility ☐other: _____

Those living in the home with client: _____

Updated Family Status:

XI. ONGOING CULTURAL ACCOMMODATIONS

☐Not indicated at this time
☐Utilization of interpreter (ongoing or occasional) Language: _____
☐Bilingual provider (ongoing or occasional) Language: _____
☐Recommended referrals that are culturally specific: _____

XII. CLINICAL CONCLUSION (Include plan, recommendations, need for further evaluation, and/or referrals)

DSM-IV-TR DIAGNOSIS (CURRENT)	DIAGNOSTIC CODE
AXIS I	
AXIS I	
AXIS I	
AXIS II	
AXIS III Relevant Medical Conditions:	
AXIS IV Psychosocial and Environmental Problems:	
AXIS V Current GAF: Highest GAF in Past Year:	

☐Yes ☐No Client meets additional Dual Diagnosis criteria of having a co-occurring substance use problem that does not meet the criteria for a substance-related diagnosis but causes significant impairment in the youth's life (this information to be captured in the Other Factor codes in InSyst).

☐Yes ☐No Client meets additional Dual Diagnosis criteria of having a parent, caretaker, or significant other with a substance use problem. When familial substance use problem causes impairment in youth's life it may be noted on Axis IV above (this information to be captured in the Other Factor codes in InSyst).

Medical Necessity Met: ☐Yes ☐No When **"no"** note date **NOA-A Issued** (Medi-Cal Clients only): _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Beneficiary Handbook was offered on:** _____

☐ **Grievance and Appeal Process explained and Brochure offered on:** _____

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered when applicable on:** _____

☐ **Language/Interpretation services availability reviewed and offered when applicable on:** _____

Completed by:

_____ _____
Print name Credentials

_____ _____
Signature Date

Reviewed by:

_____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Printed name, credentials, signature

_____ _____
(Required when completed by a Trainee or when new clinician takes on case) Date
Printed name, credentials, signature

INITIAL SCREENING FORM
(Optional Format)

☆ TBS MAA Billing

WHEN:	Following walk in or telephone contact.
ON WHOM:	All unopened clients when there is a significant issue, when the client is likely to become an open case, or when the client is referred to another agency. Not required when formal episode is opened from the onset.
COMPLETED BY:	Intake staff and those staff assigned to do follow up when needed.
MODE OF COMPLETION:	Legibly handwritten, typed, or word processed on Initial Screening form (MHS-607).
REQUIRED ELEMENTS:	Narrative section to be as complete as possible and can span multiple contacts. The back section (Narrative Continued) to be used to document on-going contacts and services associated with client prior to opening of the case. When additional pages are needed, use MHS 926 progress note – other services form. Each entry is to contain the date, staff's printed/typed name, credentials, and signature of staff completing the narrative. Complete all identifying information made available such as name, age, phone number, etc. The presenting problem/need is to be noted and any available information on previous outpatient mental health treatment including diagnosis, psychiatric hospitalizations, current medications, current substance use/abuse, and current potential for harm. The overall outcome is to outline any offered appointment date for a face to face assessment, noting the time and assigned therapist. When a face to face assessment is not warranted or desired and a referral is made it shall be noted with rationale.
BILLING:	Medi-Cal Administrative Activities (MAA) billing only by Short Doyle Organizational providers who are authorized to bill MAA code 451. Follow MAA billing requirements.
NOTE:	This format is optional. Providers may design their own initial screening form to be used to capture unopened cases. If the client's case is opened to the program, the form may be placed in Assessments section of the uniform medical record. Programs, in accordance with internal policy and procedure, maintain completed forms that do not result in an open case. May choose to note time spent on each activity so it can be captured for MAA billing, when applicable (not a MAA billing requirement).

INITIAL SCREENING FORM

☐Request for Service Log Completed

Date: _____ Time: _____ Staff: _____

MediCal: Yes / No Other Insurance: _____

Client's Name: _____ Age: _____ DOB: _____

SSN: _____ Ethnicity: _____ Language: _____

Address: _____

Parent / Guardian's Name: _____ Phone: _____

Home Phone: _____ Parent's Work Phone: _____

Caller's Name: _____ Relation to Client: _____

Who to call back: _____ Phone Number: _____

CWS Worker / Probation / Other: _____ Number: _____

School/District: _____ Grade: _____ Teacher: _____

School Classification: IEP SED AB2726 None Other: _____

Presenting Problem:

_____

_____

_____

_____

Previous Outpatient Mental Health Treatment including Diagnosis:

_____

_____

Psychiatric Hospitalizations: (dates and facility).

_____

Current Medications:

_____

Current Substance Abuse:

_____

Current Potential for Harm:

_____

Outcome:

Appt Date: _____ Time: _____ Therapist: _____

Referred to: _____ Rationale: _____

☐Continued on Reversed Side

Progress Notes (Outline disposition and plan. Date and Sign each entry including credentials. If additional pages are needed, use MHS 926 progress note - other services. May choose to track time spent on each activity for MAA billing.)

YOUTH TRANSITION SELF-EVALUATION

WHEN:

For clients 16 years and older, within 30 calendar days of opening the client's episode according to age (see "On Whom"). When client has been in the System of Care, the evaluation form should be requested from the prior provider. If the evaluation is not received prior to the thirty days, a new evaluation shall be completed.

ON WHOM:

All clients age 16 years and older, including those already in the Children's Mental Health System of Care. The evaluation form must be updated annually, at age 17 ½, and yearly thereafter until client is discharged from Children's Mental Health System of Care.

Reminder that this requirement does not exclude Medication Only cases. In reviewing the evaluation, the psychiatrist shall use clinical discretion as to which items are critical and warrant actions/comments or referral back to case management or mental health services.

COMPLETED BY:

Adolescent shall complete the evaluation, and when needed staff may assist the adolescent in completing the form.

MODE OF COMPLETION:

Legibly handwritten on Youth Transition Self-Evaluation form (MHS-624).

REQUIRED ELEMENTS:

Date the evaluation was completed. The following five life domains are rated by circling a one to five scale or non applicable: Health / Mental Health, Social Skills, Daily Living Skills, Financial, and Educational / Vocational. A one on the scale represents a "no, not at all" response, a three indicates "somewhat" and a five reflects a "yes, definitely" answer. **Staff to address any items that result in a score of less than 3 by a written comment in the Action section of the form.**

BILLING:

Completing the evaluation and reviewing the youth's responses is often done as part of a session. That contact needs to be summarized in the appropriate progress note format. After rendering a service, the correct progress note form is to be completed adhering to the specific documentation standards. A billing record shall be completed for each progress note entry. See the Billing section of the Progress Note for specific billing instructions.

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

NOTE:

Item may be imported from previous episodes or other providers.

March, 2005

Date Completed: _____

Please read each of the following LIFE DOMAIN statements and circle the answer that sounds the most like you:

HEALTH/MENTAL HEALTH	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to keep my mental health services, or get them going again.	1	2	3	4	5	N/A
2. I know how to get a copy of my file if I need one.	1	2	3	4	5	N/A
3. I know what problems I have and how to get the help I need.	1	2	3	4	5	N/A
4. I know how to find a therapist or doctor and how to make an appointment.	1	2	3	4	5	N/A
5. I know the names of the medicines I take.	1	2	3	4	5	N/A
6. I know and can say why I take the medicines.	1	2	3	4	5	N/A
7. I know how to get more of my medicine so I don't run out.	1	2	3	4	5	N/A
8. I know how to get help if I have a problem with drugs or alcohol.	1	2	3	4	5	N/A
9. I know what taking illegal drugs, alcohol or smoking can do to my body.	1	2	3	4	5	N/A
10. I can explain the side effects my medicines can cause.	1	2	3	4	5	N/A
11. I show appropriate self-control.	1	2	3	4	5	N/A
12. I know some things I can do to deal with stress.	1	2	3	4	5	N/A
13. I know how I can prevent pregnancy & sexually transmitted diseases.	1	2	3	4	5	N/A

ACTIONS/COMMENTS: _____

SOCIAL SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. During my free time, I find something to do that doesn't get me into trouble.	1	2	3	4	5	N/A
2. I have positive free time activities that I enjoy.	1	2	3	4	5	N/A
3. I am involved in group activity (sports, youth group, etc.).	1	2	3	4	5	N/A
4. I can explain how I am feeling.	1	2	3	4	5	N/A
5. I can handle things that make me mad without yelling, hitting, or breaking things.	1	2	3	4	5	N/A
6. I talk over problems with friends/family.	1	2	3	4	5	N/A
7. I am willing to have my family or friends help me.	1	2	3	4	5	N/A
8. I have friends my own age.	1	2	3	4	5	N/A
9. I know how to be polite to others.	1	2	3	4	5	N/A
10. I am able to introduce myself to new people.	1	2	3	4	5	N/A
11. I know how to be a good listener, and ask questions when I need to understand better.	1	2	3	4	5	N/A
12. I know some ways I could help others who live near me.	1	2	3	4	5	N/A
13. I can explain my own cultural background.	1	2	3	4	5	N/A

ACTIONS/COMMENTS: _____

DAILY LIVING SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know who to call if there is an emergency.	1	2	3	4	5	N/A
2. I keep my teeth and body clean.	1	2	3	4	5	N/A
3. I know how to do my own laundry.	1	2	3	4	5	N/A
4. I keep my room clean.	1	2	3	4	5	N/A
5. I know how to buy things at the grocery store.	1	2	3	4	5	N/A
6. I know how to cook my own meals.	1	2	3	4	5	N/A
7. I know what foods I should eat to keep me healthy.	1	2	3	4	5	N/A
8. I know how to get a driver's license or California I.D.	1	2	3	4	5	N/A
9. I know how to use buses or other public transportation.	1	2	3	4	5	N/A
10. I can give somebody directions to where I live.	1	2	3	4	5	N/A
11. I can take care of myself if I am sick or get hurt, and I know where to get help.	1	2	3	4	5	N/A
12. I know how to get something fixed at home if it is broken.	1	2	3	4	5	N/A
13. I know what could be unsafe in my home and how to fix it.	1	2	3	4	5	N/A
14. I know how to find a place to live.	1	2	3	4	5	N/A
ACTIONS/COMMENTS:						

FINANCIAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to manage my money so I can always pay my bills.	1	2	3	4	5	N/A
2. I know how to write a check, use a credit card or a debit card, and I know how to pay by cash and get the right change back.	1	2	3	4	5	N/A
3. I know how to decide what to buy first if I want several things and don't have enough money for everything.	1	2	3	4	5	N/A
4. I can explain the good & bad points of buying on credit.	1	2	3	4	5	N/A
ACTIONS/COMMENTS:						

EDUCATIONAL/VOCATIONAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know what helps me learn new things.	1	2	3	4	5	N/A
2. I know what I like to do.	1	2	3	4	5	N/A
3. I know what I am good at doing.	1	2	3	4	5	N/A
4. I know what my educational goals are.	1	2	3	4	5	N/A
5. I know how to meet my educational goals.	1	2	3	4	5	N/A
6. I know what kind of job or career I would like to have.	1	2	3	4	5	N/A
7. I can explain the education and/or training needed for my career options.	1	2	3	4	5	N/A
8. I can find out what kinds of activities/classes an organization offers.	1	2	3	4	5	N/A
9. I know coming to work on time every day is very important, and I can do it.	1	2	3	4	5	N/A
10. I get my work done on time.	1	2	3	4	5	N/A
11. I follow directions from my supervisor/teacher.	1	2	3	4	5	N/A
ACTIONS/COMMENTS:						

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

Client: _____

InSyst #: _____

Program: _____

TRANSITIONAL YOUTH REFERRAL PLAN

NOTE: See Transitional Age Youth Referral Policy and Procedure No. 01-01-114 for more details.

WHEN: Children's Mental Health Provider is unable to make a routine or successful referrals to Adult Mental Health Services.

ON WHOM: Any client attaining 18 years (or older) who is assessed by current Children's Mental Health provider to be a candidate for Adult Mental Health Services. Only needs to be done when direct referral to Adult Mental Health Services has not been successful.

COMPLETED BY: MD, Clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, RN, trainee, QMHP, rehab specialist, rehab staff, or paraprofessional.

MODE OF COMPLETION: Legibly handwritten, typed, or word-processed on Transitional Youth Referral Plan form (MHS-605).

REQUIRED ELEMENTS: This is a three part process, with the first section being completed by the referring Children's Mental Health provider and forwarded to the Adult Mental Health Regional Program Coordinator (RPC). The second section is completed by the RPC or designee and returned to the referring party. The third section is only necessary when the linkage has not been successful and is completed by the RPC or designee and signed by the assigned team member. The form is then returned to the referring party.

Section I

- Completed by Children's Mental Health provider
- Staff and agency identifying information
- Client's identifying information
- Outline of past attempt by referring party to connect client to Adult Mental Health Services
- Other comments
- Required attachments – see Policy and Procedure No. 01-01-114

Section II

- Completed by RPC/designee and returned to Children's provider who initiated request
- RPC/designee response/plan
- Name of program referral was made to with contact information
- RPC/designee's contact information
- Date response was forwarded to referring party

Section III

- Completed by RPC/designee only when the linkage is not successful. RPC/designee shall coordinate an initial meeting with a multidisciplinary team within two weeks of the initial referral
- Date of initial meeting
- Multidisciplinary team members names and signatures
- Transition plan recommendation
- Name of individual responsible to follow up on plan, with contact information
- Date copy of completed form was sent to original children's referral source
- Notation if client accepted plan, outlining an alternative if client did not accept plan

The T bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

For Day Programs, which provide an all-inclusive rate, document the process on the daily note or weekly summary.

TRANSITIONAL YOUTH REFERRAL PLAN

(SEE TRANSITIONAL AGE YOUTH REFERRAL POLICY AND PROCEDURE 01-01-114 FOR MORE DETIALS)

Section I (completed by Children's program with attached referral packet and releases)

Staff Name: _____ Date: _____
Referring Program: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email: _____

Client's Name: _____ Birth Date: _____
Client's Address: _____
Phone Number: _____
Insurance Status: _____
Current Diagnosis: _____
_____
Services currently receiving: _____
_____
Services needed from Adult Mental Health System of Care: _____
_____

I have attempted to refer to the following Adult Mental Health Programs unsuccessfully (include all attempts and outcome);

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____
_____
_____

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____
_____
_____

Other Comments: _____
_____
_____
_____
_____
_____
_____
_____

SECTION II (completed by RPC / designee & provided to Children's provider who initiated request)

Regional Program Coordinator's (RPC) Response:

☐ deny services because client does not meet medical necessity criteria

☐ youth 18 and over; an assessment will be requested from an adult provider agreeable to the client and family (see specifics below)

☐ other (see specifics below)

Program referred to: _____

Staff Name/Contact: _____

Phone Number: _____ Fax Number: _____

_____

_____

_____

RPC / Designee's Name: _____ Date: _____

Phone Number: _____ Fax Number: _____

Email: _____

☐ Date response was forwarded to referring party: _____

SECTION III (Completed by RPC when the linkage is not successful. RPC shall coordinate an initial meeting with a multidisciplinary team within two weeks of the initial referral.)

Date of initial meeting: _____

Multidisciplinary Team Members Names and Signatures: _____

_____

_____

Transition Plan Recommendation: _____

_____

_____

_____

_____

Individual to follow up on Plan: _____

Phone Number: _____ Fax Number: _____

Email: _____

☐ Date copy of completed form sent to original children's referral source: _____

Youth accepted plan: ☐ Yes ☐ No ☐ Other: _____

_____

(when "no" an alternative shall be identified & same procedure followed)

SECTION III

OUTCOME EVALUATIONS

CLIENT PLAN

WHEN:

By the end of the assessment period, which is 30 calendar days from opening the client's episode. Additionally, a Client Plan (CP) shall be completed whenever there is a significant change in the client's planned care. The CP shall also be rewritten prior to presenting the client's case to the Utilization Review (UR) Committee (which must occur prior to the end of the first six months of treatment, and subsequently following the recommendation of the UR Committee). CP may be completed one month prior to the CP due date.

Day Treatment Intensive Programs require an additional update of the CP three months following the opening of the client's episode. As in outpatient programs, the CP is rewritten every six months from the episode opening; however, it must also be updated every three months utilizing the episode opening date as the guide.

Unplanned services such as Crisis Intervention (CI), or inpatient stays do not require a CP. Medication only clients do not require a CP due to having medication plans documented in the progress notes. Therapeutic Behavioral Services complete the TBS Treatment Plan.

ON WHOM:

All clients with open episodes of thirty days or longer, excluding medication only cases and unplanned services such as CI or inpatient stays.

COMPLETED BY:

MD, Clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, RN, trainee, QMHP, rehab specialist, rehab staff, or paraprofessional.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Client Plan form (MHS-646).

REQUIRED ELEMENTS:

Admission date, services provided (MHS, CMBR, Day Program, Meds), interval covered by Client Plan, and anticipated discharge date. Outline if client was offered copy of plan, if plan was explained in client's and guardian's primary language, with explanation when it is not. Identify client's strengths and challenges. The client's presenting problem(s) with specific behavior(s) and frequency shall be noted and be consistent with the presenting problem and diagnosis. Follow by outlining the goal/desired outcome with specific objective(s), which delineate how it will be measured, by whom, and noting when it is achieved. Include the anticipated duration to achieve objectives and interventions, specifying modality, frequency, and titration plan.

For AB2726 clients, the goals and objectives of the Individualized Education Plan (IEP) Mental Health Service Plan must be integrated on the CP. Additional goals and objectives may also be included on the CP, but may not replace the IEP treatment plan goals.

The next section of the CP shall concentrate on the coordination of current resources and anticipated transition/discharge plan. It shall outline any other Children's Mental Health services offered, community resources, alcohol/drug services, or any other services or recommendations. Note if a referral to Adult Mental Health is appropriate. Complete the CP by obtaining the client's signature with date, making sure to cross-reference the date of a progress note explaining when a client's signature is not obtained. Guardian signature with date to be obtained, noting when client is dependent of the court and therefore no signature is obtained, or cross-referencing the date of a progress note explaining when a guardian's signature is not obtained for any other reason. Efforts shall be made to obtain guardian's signature and involvement in CP development. However, when guardian is not available to sign the plan but provides verbal authorization, note discussion on progress note and cross-reference the date on the CP. At a later time, when guardian is available to sign, signature shall be obtained. Finally, the service staff shall sign name with credentials and date.

Signature updates shall be obtained whenever an addition or modification is made to the CP, and at the three-month interval for Day Treatment Intensive Programs.

The T bar shall be completed with the client's name, InSyst number, and program name.

BILLING:

Billing for writing, updating or amending a CP shall only occur when it is connected to a direct client service such as an individual or assessment session by a clinician or a direct client contact with a QMHP, rehab specialist/staff, or paraprofessional. Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

When writing, updating, or amending a CP that is not connected to a direct client service, document that work on a progress note and utilize a non billable code and corresponding billing record.

For Day Programs which provide an all inclusive rate, document the writing, updating or amending of a CP on the daily note or weekly summary.

SECTION IV

PLANS

Admission Date: _____ **Services:** ☐MHS ☐CM/BR ☐Day Program ☐Meds

Anticipated Discharge Date: _____

Interval Covered by Client Plan: **From:** _____ **To:** _____

Client offered copy of plan? ☐Yes ☐No

Explained in Client's Primary Language which is ☐English ☐Spanish ☐Vietnamese ☐Arabic ☐ _____

If not, explain: _____

Explained in Guardian's Primary Language which is ☐English ☐Spanish ☐Vietnamese ☐Arabic ☐ _____

If not, explain: _____

Client's Strengths: _____

Client's Challenges: _____

Client's Presenting Problem/Need # 1: _____

Behavior: _____ **Frequency:** _____

Behavior: _____ **Frequency:** _____

Behavior: _____ **Frequency:** _____

Goal/Desired Outcome: _____

_____

Objective 1: _____

_____

As Measured By: _____

Achieved On: _____ Staff Name: _____

Objective 2: _____

_____

As Measured By: _____

Achieved On: _____ Staff Name: _____

Objective 3: _____

_____

As Measured By: _____

Achieved On: _____ Staff Name: _____

Anticipated Duration to Achieve Objectives: _____

Interventions (modality/frequency/titration plan): _____

_____

_____

Client's Presenting Problem/Need # 2: _____

Behavior: _____ **Frequency:** _____

Behavior: _____ **Frequency:** _____

Goals/Desired Outcomes: _____

_____

Objective 1: _____

As Measured By: _____

Achieved On: _____ Staff Name: _____

Objective 2: _____

As Measured By: _____

Achieved On: _____ Staff Name: _____

Anticipated Duration to Achieve Objectives: _____

Interventions (modality/frequency/titration plan): _____

_____

_____

COORDINATION OF CURRENT RESOURCES AND ANTICIPATED TRANSITION / DISCHARGE PLAN

Other Children's Mental Health Services: _____

Community Resources: _____

Alcohol/Drug Services: _____

Other: _____

Referral to Adult Mental Health: ☐Yes ☐No ☐NA (client is under the age of 18)

SIGNATURES:

Client: _____ Date: _____

☐See progress note dated _____ for explanation when client's signature is not obtained.

Parent/Guardian: _____ Date: _____

☐No signature due to client being a dependent of the court.

☐See progress note dated _____ for explanation when guardian's signature is not obtained.

Service Staff: _____ Credentials: _____ Date: _____

UPDATE:

Client: _____ Date: _____

☐See progress note dated _____ for explanation when client's signature is not obtained.

Parent/Guardian: _____ Date: _____

☐No signature due to client being a dependent of the court.

☐See progress note dated _____ for explanation when guardian's signature is not obtained.

Service Staff: _____ Credentials: _____ Date: _____

IEP MENTAL HEALTH TREATMENT PLAN (AB2726)

NOTE:

AB2726 clients served by an AB2726 provider must have a current copy of their mental health Individualized Educational Plan (IEP) in the medical record. This IEP Mental Health Treatment Plan is a legal document that must be implemented, monitored, and progress reviewed on an on-going basis. It contains goals that address the impediment of mental health issues that hinder the student's ability to benefit from his/her special education program. It must be kept current and is utilized to develop the client's Client Plan (MHS-646). The AB2726 provider is responsible for having the IEP amended when/if the IEP Mental Health Treatment Plan goals have been met or are not reflective of the client's issues/needs as related to his/her special education program.

WHEN:

Upon completion of the initial AB2726 mental health assessment, whenever an AB2726 provider is treating an AB2726 client a current IEP Mental Health Treatment Plan must be available in the client's medical record.

ON WHOM:

All AB2726 Clients. AB2726 providers must have current copy of the IEP Mental Health Treatment Plan.

COMPLETED BY:

The AB2726 clinician develops the goals and objectives of the mental health services with objective criteria and evaluation procedures. Scope of practice for clinician includes MD, Clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, RN (with Masters Degree and psychiatric specialty), trainee with co-signature by a LPHA.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Mental Health Treatment Plan, located in the Appendices of the Local Interagency Agreement..

REQUIRED ELEMENTS:

Follow IEP requirements per California Special Education Program: A Composite of Laws.

BILLING:

Providers involved in the IEP process can bill for the time associated with that process based on the specific services provided. Document the service provided on the appropriate progress note (see Progress Note section), utilizing the appropriate billing code. A billing record shall be completed (see Billing portion of Progress Note section).

Day Program providers, which provide an all-inclusive rate, document any involvement in the IEP process on the daily note or weekly summary.

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES

MENTAL HEALTH TREATMENT PLAN

Date: _____ Student: _____ Type of Services: _____ Start Date: _____ Duration: _____

Area of Need:

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☐ Quarterly ☐ Trimester ☐ Semester ☐ Other _____ How? ☐ Annotated Goals/Objectives ☐ Other: _____	1. _____ 2. _____ 3. _____ 4. _____	1. _____ 2. _____ 3. _____ 4. _____	☐ Yes ☐ No _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No _____

Benchmark/Short-Term Objective:	Date: Achieved ☐ Reviewed ☐
Person(s) Responsible: _____	
Benchmark/Short-Term Objective:	**Date:** **Achieved ☐ Reviewed ☐**
Person(s) Responsible: _____	

Area of Need:

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress	Periodic Review Dates	Progress Toward Goal	Sufficient Progress to Meet Goal
☐ Quarterly ☐ Trimester ☐ Semester ☐ Other _____ How? ☐ Annotated Goals/Objectives ☐ Other: _____	1. _____ 2. _____ 3. _____ 4. _____	1. _____ 2. _____ 3. _____ 4. _____	☐ Yes ☐ No _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No _____ ☐ Yes ☐ No _____

Benchmark/Short-Term Objective:	Date: Achieved ☐ Reviewed ☐
Person(s) Responsible: _____	
Benchmark/Short-Term Objective:	**Date:** **Achieved ☐ Reviewed ☐**
Person(s) Responsible: _____	

_____ _____ _____ _____

Signature of Mental Health Service Representative **Date** **Signature of Parent** **Date**

THERAPEUTIC BEHAVIORAL SERVICES (TBS)
TREATMENT PLAN

WHEN:

The **Initial Meeting** provides an opportunity for the TBS team to identify the client's strengths, target behaviors, and possible interventions. The TBS case manager uses this information to create the TBS Treatment Plan, which is finalized, approved, and signed by the TBS team at the follow-up **Implementation Meeting**. At least a minimal treatment plan shall be completed by the end of the initial authorization period (thirty days from the contractor's opening the client's episode).

Additionally, a Treatment Plan shall be reviewed and updated at each monthly review meeting and whenever there is a significant change in the client's planned care. The Treatment Plan shall also be rewritten at the third month review meeting and prior to presenting the client's case to the Utilization Review (UR) Committee (which must occur prior to the end of the first six months of treatment, and subsequently following the recommendation of the UR Committee).

The TBS case manager shall provide a copy of all Treatment Plans and updates to the County TBS facilitator.

ON WHOM:

All clients who receive TBS services. Occasionally there are clients who are approved for TBS, but for some reason do not actually receive services. These clients are not required to have a TBS Treatment Plan.

COMPLETED BY:

MD, Clinical or waivered Psychologist, licensed or waivered LCSW, Licensed or waivered MFT, RN (with Masters Degree and psychiatric specialty). Trainees, QMHPs, rehab specialists, rehab staff, or paraprofessionals may write the treatment plan with the co-signature by a LPHA.

The case manager for the TBS contractor is required to complete a Treatment Plan for each client. The case manager shall have the TBS team sign the TBS Treatment Plan and offer a copy of the plan to each team member, which includes the client. The County facilitator approves services based on the TBS Treatment Plan.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on TBS Treatment Plan form (MHS-919).